Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

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State/Territory: **DELAWARE**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name(s): **DELAWARE HEALTHY CHILDREN'S PROGRAM (DHCP)**

SCHIP Program Type:
____Medicaid SCHIP Expansion Only
__**X**__Separate SCHIP Program Only
_____Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

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Submission Date: _____

(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)
Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility – No Change

B. Enrollment process – No Change

C. Presumptive eligibility – No Change

D. Continuous eligibility – No Change

E. Outreach/marketing campaigns

The School Nurse Express Program began in March, 2001. Through this project, funded by the March of Dimes through a Robert Wood Johnson Foundation grant, self-declaration of income was piloted. Initial marketing was conducted to recruit nurses into the program (see attached). School nurses conduct outreach to their student population based on medical information (e.g., insurance coverage) they receive at the beginning of each school year. The project rewards school nurses for each successful enrollment into the DHCP they submit by contributing to their school nurse enrichment fund. Approximately 20-30% of all applications are referred by school nurses. Because of this program, outreach efforts in 2001 did not include sending a DHCP information card to every school child. The response rate resulting from targeted outreach provided through the School Nurse Express program has far outweighed the response from any mass mailing done in previous years. 24 of the 27 public school districts elected to participate. Presentations were made at school nurse in-services. Materials were developed. School districts are paid $50.00 for every application that is approved for either Medicaid or DHCP. School Districts are encouraged to use the incentives to fund school nurse development. Another component is the use of application by declaration of income for those families assisted by the school nurse. Through 9/30/01, SNE generated 178 applications. 139 were approved, 72 for Medicaid and 49 for DHCP. A total of 225 children and 96 adults were enrolled through this project through 9/30/01. The project will continue through the 2002 school year.

Additionally, in 2001, the DHCP implemented and marketed simplified payment options. Enrollees now have the option of paying premiums at all Happy Harry's drug stores in Delaware,

as well as via the internet and over the phone. Marketing took the form of inserts in DHCP premium invoices and information at Happy Harry's stores.

F. Eligibility determination process – No Change

G. Eligibility redetermination process – No Change

H. Benefit structure – No Change

I. Cost-sharing policies

The State instituted a "premium holiday" between July 1, 2000 and December 31, 2000. The moratorium was a pilot project designed to evaluate whether the waiving of premiums would increase enrollment. Beginning with an enrollment level of approximately 2,854 (cards issued), the pilot reached a high of 4,014 (cards issued) in February 2001. Since the premium holiday finished as of December 2000, enrollment has decreased and returned to just under 3,300 (cards issued). It appears that there is a core number of families who value the program even with its premiums, but others only sought out coverage when the premium was waived. Discussion continues on whether to maintain or waive the premiums.

J. Crowd-out policies – No Change

K. Delivery system – No Change

L. Coordination with other programs (especially private insurance and Medicaid) – No Change

M. Screen and enroll process – No Change

N. Application – No Change

O. Other – No Change

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

The number of uninsured children between 101-200% FLP below 18 dropped from 11,913 in the previous year to 8,229 based on 3 –year average. Source is the Center for applied Demography and Survey Research, University of Delaware.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

The number of children enrolled in Medicaid in Medicaid is 3,637 which is a 1:1 ratio. Data Source is Medfac Report.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

Not Applicable

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

Not in the review period. This will be covered net year.

____ No, skip to 1.3

____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
To decrease the number of uninsured children and thereby improve their health and chances for life success.	Show rate of uninsured children	Data Sources: Budget, Statistical & Systems Unit Methodology: Tracking enrollment v. Universe of eligible children <= 200%FPL Numerator: # of children enrolled in FFY 2001 **= 867** in DHCP **+ 3637** children added to Medicaid = **4504** children who received some coverage during FFY 01. (Of the **XXX**X children in DHCP, **XXXX** were new to the program in FFY 01)

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Denominator: Universe of uninsured children with family incomes under 200% of FPL (not already in Medicaid) = **14,981 (8,229 + 6,752 Medicaid)** Progress Summary: 68% SCHIP enrollment rate in year three; 62**%** overall enrollment rate for uninsured in FFY 01
Objectives Related to SCHIP Enrollment		
None specified in plan		Data Sources: – No Change Methodology: – No Change Progress Summary: – No Change
Objectives Related to Increasing Medicaid Enrollment		
None specified in plan		Data Sources: Methodology: Progress Summary:
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
To go from a clinical based system (fee-for-service/sick care) to a community-based system (managed	Percentage decline in unnecessary emergency room visits.	Data Sources: MCO encounter data & baseline survey Methodology: Survey of Pre and Post-SCHIP experience

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
(managed care/preventive care) which provides genuine access to high quality care.		Numerator: # of ER visits after enrollment Denominator: # of projected ER visits prior to SCHIP Progress Summary: ER use prior to SCHIP (a 25% use rate) was determined through a baseline study completed by the University of Delaware. Unexpected fiscal restraints prevented the State from conducting the planned ER study. Also, an alternate source of the data which could potentially be used to measure R was use (encounter data) may be of uncertain quality. We will continue to attempt to collect the data and evaluate its usefulness. If the data proves to be unusable, the State may need to reconsider this objective.
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
To maintain uninsured children in the health care industry so they receive the same quality of care as insured children	Percentage increase in wellness visits	Data Sources: MCO encounter data & baseline survey Methodology: DB2 queries Numerator: # of well child visits after enrollment Denominator: # of projected well child visits prior to SCHIP Progress Summary: This objective needs to be reevaluated. Pre-SCHIP baseline is unavailable and encounter data is incomplete.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Other Objectives		
None specified in plan		Data Sources: Methodology: Progress Summary:

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

– No Change

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

N/A

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Not Applicable

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

Overview of DHCP Enrollment During
6-Month Free Premium Promotion

The chart below illustrates the change in Delaware Healthy Children Program enrollment and disenrollment during the Division of Social Services pilot to eliminate the premium payment for the first 6 months on all newly eligible clients from July to December 2000.

During the first six months of 2000, an average of 74 clients per month transitioned back into Medicaid from the DHCP. However, during the promotion period, only 18 clients per month transitioned into Medicaid. Interestingly, when the promotion ended and clients began receiving an invoice for the premium payment, the number that transitioned into Medicaid increased to an average of 61 per month (January-June 2001).

Overall, the DHCP disenrollments have returned to a similar rate as was experienced prior to the 6-month premium waiver period.

	Change in enrollment/disenrollment		
	January – June 2000	**6 month free pilot period July – December 2000**	**January – July 2001**
Enrolled during period	1774	1989	2518*
Total of All Enrolled in DHCP	2820	3787	3251*
Total Disenrolled	1326	514	1496
Avg. Disenrolled per month	221	86	249
Transition from DHCP to Medicaid	443	110	365
Avg Transition to Medicaid per month	74	18	61
No longer Eligible for DHCP	673	255	443
Avg. No longer eligible per month	112	43	74
Total Re-enrolled in DHCP	723	514	649
Avg. Re-enrolled in DHCP per month	121	86	108

*Based on nine-month data, January through September 2001. The HBM continuously evaluates DHCP disenrollments and is currently contacting those who disenrolled in July 2001.

EDS' Health Benefits Manager also has contacted clients who have called for a DHCP application, but have never returned it. To date, 149 families have been contacted. Listed below,

in order of frequency of response, are some key reasons clients have not returned the DHCP application:

- Obtained other insurance.
- Did not think they would qualify because of their income.
- Waiting to obtain their pay stubs.
- Do not want help from Social Services.
- Returned the application in person to the Social Services Center rather than mailing it.
- Approved for Medicaid.

School Nurse Express
Pilot Evaluation

Pilot Objectives

- Increase enrollment in the Delaware Healthy Children Program (DHCP) through the use of a school nurse based outreach approach.
- Simplify and facilitate the application process through the use of income declaration while maintaining program integrity.

Background

The School Nurse Express (SNE) Pilot Project was launched on February 1, 2001 with a $10,000 grant from the March of Dimes and the Robert Wood Johnson Covering Kids Grant. Twenty-four out of twenty-seven public and charter school districts agreed to participate in the pilot. An incentive payment of $50 will be given to each district for every approved Medicaid and DHCP application. The money is designated only for the nurse professional development fund or to purchase medical supplies for the nurse's office. The referred families are tracked and a designated Division of Social Service (DSS) worker processes the applications.

Pilot Evaluation

In compliance with federal rules and regulations from the Centers for Medicare and Medicaid Services (CMS), all states allowing income declaration are required to review ten percent of all cases for financial and program accuracy. Application processing time will also be compared with application processing from the RWJ Covering Kids New Castle Pilot Project and with applications submitted to DSS offices located at State Service Center sites. Randomly selected applicants will be asked to complete a survey.

As of 9/30/01, the SNE Pilot Project received a total of 178 applications. 18 of these applicants

were randomly selected and sent a request for verification of all earned and unearned income. The majority of SNE applicants submitted income verifications along with their original applications despite verbal and written disregard for this requirement. Of the 178 applications received, 139 were approved (72 for Medicaid and 49 for DHCP). A total of 255 children and 96 adults were now eligible for health care coverage (Medicaid: 96 adults, 151 children, DHCP: 104 children). A total of 22 applications were denied; 14 due to over-income, 2 were ineligible due to alien status and 6 failed to provide requested information regarding earnings. These applicants failed to declare their earnings on the application and did not respond to the request to declare income. Additionally, 11 duplicate applications were received during this time period.

For the SNE evaluation we were unable to compare the rate of income verification denials for all programs due to project limitations. However, we were able to compare the findings between the SNE and RWJ NCC Covering Kids pilots. The SNE pilot denied only 6 of 178 applications for failing to declare their gross monthly income. This represents a denial rate of 3.3%. The RWJ NCC Covering Kids pilot denied 152 of 178 applications for failing to provide income verifications; representing a denial rate of 85.4%.

Financial/Category Eligibility Review

- 16 applicants reported income accurately and determined eligible for the correct MA/DHCP category
- 2 applicant under-reported their income:
  - one applicant increased income but remained eligible for DHCP at a higher premium level
  - one applicant increased income and was determined ineligible for DHCP (the income under-reported was by less than $100 $3041>$2942)

These represent 94.4% of applicants who were income eligible based on reported and reviewed income.

The evaluation of these applicants was based on current income. Due to the limited scope and resources of the pilot project, we were not able to review income for the month of application. Should declaration of income be adopted by DSS, the Quality Control staff would have the resources to access income verifications at the point of application. The DHCP guarantees a year of eligibility despite income increase during that period of eligibility. Given the slight income increases in the two cases in question, it is likely that the income increase could possibly reflect a salary increase received after their application to the DHCP.

According to The Southern Institute on Children and Families 1998 report **The Burden of Proof: How Much is Too Much For Child Health Coverage,** income verifications represent a substantial barrier to application. The State of Georgia has been a leader in eliminating income verification demands on families and their Medicaid officials have testified that they have not experienced quality control problems as a result.

Case Processing Comparisons

Counting from the protected filing date on Medicaid only applications to the date of confirmation in DCIS II, the number of days were tabulated and divided by the number of applications to arrive at the average processing time. Although the income verifications were not required, alien status verifications were required and declared information such as date of birth, social security numbers and applicant signature were required for case completion purposes. The RWJ Covering Kids New Castle Pilot was selected as one comparison model, as it pays an incentive for approved applications which are processed by a designated DSS worker. The other comparison model used was the DSS State Service Center application process. The DSS applications are assigned to caseworkers based on alpha and zip code location. The DSS workers are additionally responsible for determining eligibility for Cash Assistance, Food Stamps and Child Care programs. Both RWJ and DSS State Service Center applications required income verifications.

- *SNE applications averaged 5.38 days to complete*
- *RWJ applications averaged 21 days to complete*
- *DSS applications averaged 63.3 days to complete*

The elimination of income verifications greatly reduced processing time. For DHCP eligible children, it reflects at least one month possibly two months of access to health care coverage.

Survey Findings

What prompted you to apply for DHCP?

61% -school nurse
27%-need for health insurance
11%-no employer-based health coverage
5%-child was ill

Would you have applied for DHCP without the letter from the school nurse?

Yes- 33%
No- 66%

Were you satisfied with the application process?

Yes- 100%

Was the application simple and fast?

Yes- 100%

Do you think that supplying income verifications with the application prevents some families from applying?

33%- feel it is a barrier
16%-feel that it may be a barrier
16%-feel it is not a barrier
16%-feel welfare stigma is the barrier to applying
16%-afraid that they were over-income
2%-embarrased to admit that they did not have health care coverage for their children

Can you think of any other reasons why families may be discouraged from applying for health care coverage?

27%-were unaware DHCP existed
11%-feared they would not qualify
5%-welfare stigma; DSS staff is not helpful and are unfriendly to clients
5%-feared hidden costs to program
Additional comments included:
No dental program
Limited access to providers
Income guidelines too low
Six month waiting period too long and unfair
Did not know how to access DHCP
Did not want to reveal personal information

Many applicants listed more than one answer to the questions presented, survey results represent a compilation of all answers given.

Evaluation Summary

The evaluation of SNE pilot objectives indicates that the use of the school nurse outreach is successful in reaching and enrolling children in DHCP. The number of children enrolled in DHCP within a six-month time period for SNE is 104; RWJ NCC Covering Kids Pilot, spanning a two-year period, has approved 79 children for DHCP.

Elimination of income verification significantly decreased processing time. The majority of applicants reported their income accurately. Families were often able to access health care services within 30 days of application submission. Program integrity was not compromised.

The overall opinion of the applicants was that the school nurse was the catalyst to their submission of the DHCP application. The declaration of income removed a barrier to applying, decreased the stigma of welfare and speeded the application process.

SEE APPENDIX A - Executive Summary prepared by William M. Mercer, Inc.

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage: N/A

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

_____Number of adults
_____Number of children

C. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in: N/A

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

_____Number of adults
_____Number of children

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

Crowd-out is the substitution of public insurance for private coverage.

B.How do you monitor and measure whether crow-out is occurring?

Under final SCHIP regulations the DHPC need not actively pursue crow-out measures since the program's eligibility limits enrollment to clients under 200% FPL

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

N/A

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Crowd-out, while not an issue for Delaware, is discouraged by imposing three conditions pertaining to private health insurance:

- The child must have been uninsured in the six months prior to DHCP application;
- The child had insurance in the preceding six months, but it was not comprehensive. Comprehensive is defined as coverage that includes all of the following: hospital care, physician services, lab services and x-ray services.
- The child had insurance in the preceding six months, but lost coverage due to "good cause". Good cause may be due to death or disability of a parent, termination of employment, parent transition to a new employer who does not offer coverage for dependents.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

- The School Nurse Express program has resulted in 215 approved families in a 9-month period.

Outreach is conducted at a myriad of public and private organizations that serve low-income, uninsured families. Presentations are made to organization staff so that they can provide outreach to those they serve as well as to families themselves. Employees and families are encouraged to share the information with friends, family and neighbors who may qualify. While it is difficult to measure the effectiveness of such outreach efforts, the referral rate from friends, family and the "grapevine" yield the highest number of calls for applications.

A.Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

- The Community Access Program is a HRSA funded project administered by the Delaware Health Care Commission. The project places community care coordinators in hospital emergency rooms and community health centers. The result has been an increase in family applications for medical assistance—many children become enrolled in the DHCP as a result. Seventy-six percent of those that are identified by CAP are minorities.
- Outreach presentations are given at community centers and shelter, which target at-risk populations.
- Advertisement in local "items for sale" type weekly publication in our most rural county has been successful. Advertisement in statewide publications has not been successful.

A.Which methods best reached which populations? How have you measured effectiveness?

- Collaboration with the Covering Kids and CAP has reached low income, minority populations, measured by enrollment tracking
- Displays in retail stores, restaurants, post offices, tax services, etc. has reached the general public tracked by asking "how did you hear about the program?" when callers request and application.
- School Nurse Express has been successful because of the individualized, targeted approach that has resulted in a significant success rate of enrollments.
- Callers to the 800# are asked how or where did they hear of DHCP so effective outreach activities continue to be monitored.

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

- One year guaranteed eligibililty.
- The Health Benefits Manager identifies all families that disenroll from the DHCP. Those that did not revert to Medicaid are called to determine their reason for disenrolling. Statistics are kept regarding the reasons for disenrollment (attached). The majority of those that disenroll do so because they obtain other insurance or are no long eligible for the program for another reason. Those that disenroll, but are still eligible receive special assistance to re-enroll, which may take the form of a simple reminder or a premium waiver for those that have a financial barrier.

A. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

__x__ Follow-up by caseworkers/outreach workers
__x__ Renewal reminder notices to all families
__x__ Targeted mailing to selected populations, specify population
__x__ Information campaigns
____ Simplification of re-enrollment process, please describe
____Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe.
__x__ Other, please explain phone calls, premium payment simplication (drug stores, internet and pay by phone).

B. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Medicaid recipients do not receive a phone call, they do not receive a reenrollment notice (just an application in the mail) and there are no targeted mailings.

C. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

- Education provided at the time of enrollment

- Phone calls to provide a reminder and re-education opportunity.

A.What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

Of those that disenrolled between January and August 2001, 34% were enrolled in Medicaid and another 12% were due to having obtained private insurance. Another 37% are no longer eligible for medical assistance, but of those, it is unclear if they become uninsured. The remaining 20% either have moved or cannot be located.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

We have a simplified joint SCHIP/Medicaid application that is used for both applicants and for redeterminations. We provide a postage-paid envelope. No face to face interviews are required. For initial applications, we use an 800 # that is answered by competent bilingual staff that assists the callers with completing an application, which is mailed to a centralized location. This allows us to track the applications and prescreen for completeness before they are transferred to a state worker for the eligibility determination. The staff on the 800 line explain and process the managed care enrollment requirements. For both SCHIP and Medicaid, we eliminated all verification requirements except income and alien status. The annual redetermination is a mail in process completed by a state worker.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

Our automated eligibility determination system determines if families are eligible for Medicaid or SCHIP. If a family becomes ineligible for Medicaid, the system will automatically cascade the children into SCHIP. A new application is not required.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Yes, we use the same managed care organizations and primary care physicians.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

Yes, a study by the University of Delaware indicated that the premiums were a barrier to access. Also, during the 6-month period from July to December of 2000 when there was a

moratorium on premiums, caseloads increased an average of 126 per month compared to 65 per month without the moratorium.

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

Not Applicable

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results

Information on the quality of care is available as part of the EPSDT study performed by t he State's External Quality Review Organization. While SCHIP children are not specifically entitled to EPSDT services under the Delaware Healthy Children Program, the children were included in the EQRO performance measures. The MCOs are expected to provide the same level of service as required under Medicaid "EPSDT" requirements. Many of the study's results are listed below.

Overall rate of clients with a documented medical history:	45.2%
Overall rate of clients with a documented speech evaluation:	45.2%
Overall rate of clients with a documented mental health screen:	19.4%
Overall rate of clients with a documented unclothed physical:	76.2%
Overall rate of clients with a documented vision exam:	33.3%
Overall rate of clients with a documented hearing exam:	28.6%
Overall rate of clients with a documented TB test:	54.8%
Overall rate of clients with hemoglobin/hematocrit test:	23.8%
Overall rate of clients with blood lead screening:	11.9%
Overall rate of clients with documented immunizations:	76.2%

In comparison with Medicaid eligible children these rates may be higher or lower depending on the element reviewed. Clearly, emphasis needs to be given to measures to improve provider documentation and data collection to assure that quality services are being provided. Improvement efforts are addressed below.

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

Focused clinical studies are conducted by the EQRO. Separate findings are reported for Medicaid and SCHIP enrollees. The studies include focus groups designed to provide qualitative information on more subjective perceptions of the quality of care and suggestions for improvements.

Consumer assessment surveys are conducted. These surveys measure client satisfaction with the medical care and services provided through the Diamond State Health Plan, and Delaware Healthy Children Program. The survey measures the members' satisfaction with their health plans, primary doctors, ancillary services, and overall quality of care with ease of access for medical services.

Delaware Healthy Children Program members are included in statewide initiatives of the Quality Improvement Initiative Task Force and the Behavioral Health Improvement Initiative Task Force.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

As a result of the EPSDT study that was completed, a population was identified that will receive focused improvement efforts. The rates of EPSDT services for adolescents were significantly lower that other age groups. A statewide intervention has been designed and implemented to encourage adolescents to see their primary care physician. Results of this intervention should be available in fall of 2002.

SECION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility

1. Continued success in simplification of the application process:

- a return envelope is provided to a non-government address, the Health Benefits Manager.
- missing information on returned applications is immediately sought by the Health Benefits

Manager to facilitate eligibility review and minimize follow up for information.

2. Implemented a centralized unit for processing Medicaid/DHCP applications mailed into the HBM address. These are applications that were mailed to callers to the 800#. The unit was formed and trained August 2001 and we expect processing time to be quicker than the average of 30-60 days in the field offices where MA/DHCP applications complete with applications for Food Stamps, Child Care and Cash benefits.

3. HBM has produced and mails a letter to families with children transitioning from Medicaid to DHCP to explain the premium and change in benefits. The letter invites the parents to call for more information. Nearly 90% of the parents call. This appears to reduce confusion about the change.

B. Outreach

Success: School Nurse Express (please see section 2.4)

Barriers: Experience proved that at outreach "events" held on weekends, which were family-oriented did not prove to be successful because families were not interested at that time in learning about healthcare options. They often took information or applications, but the response rate was very low.

C. Enrollment

When prospective families call the HBM for an application, a record of those requests is kept in order to conduct follow up and statistical analyses. Between April and June 2001, the HBM called all prospective families who called for a DHCP application but never returned it. The majority of potential enrollees who did not return the application were unable to be reached (disconnected phone, have moved, etc.). Other reasons for not submitting the application were that the family obtained other insurance, were no longer interested or had not had a chance to complete the application. (see attached for summary of phone responses.)

D. Retention/disenrollment

Two months prior to the client's 12-month enrollment period ending, they receive a new application in the mail. This application is not accompanied with information that alerts the family to complete it as part of the re-enrollment process. This presents a significant barrier as clients think that they are already enrolled and there is no need for them to complete the application. As a result, families are denied eligibility for the next 12-month period due to non-response.

E. Benefit structure

The lack of dental and non-emergency transportation services is seen as a barrier to the CHIP program. Information regarding this was printed on the CHIP medical cards to clarify this difference in the service package.

F. Cost-sharing

Please refer to Section 1.7.

G. Delivery system

Not Applicable

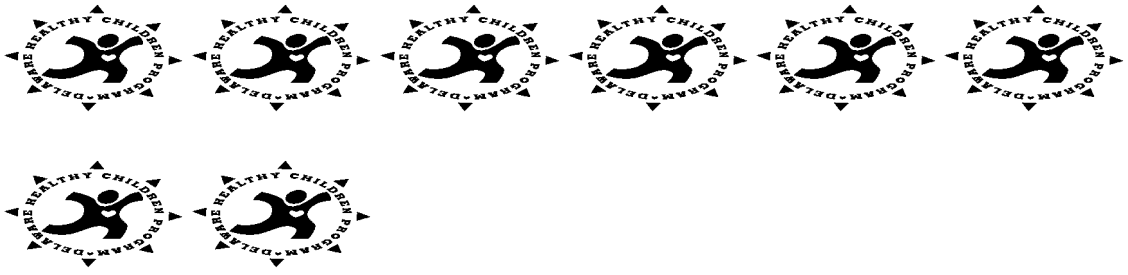
H. Coordination with other programs

Partnered with H&R Block to ensure as many children as possible got the information on CHIPS. For every tax return they processed with the family income under 200% of the poverty and eligible for the earned income credit a note was placed on the return to contact the national 800 number for Covering Kids. In addiction we went to every H&R Block office in the state and placed information and talked to staff about the program.

The Corporate offices of TJ Max called and asked if we could contact their store and give information to the store manager about the CHIPS program. They employ many part time employees who do not have health insurance. We went to every store to give out materials and post information.

I. Crowd-out

J. Other



Good news !!!!! Good news!!!!!

Happy Harry's Drug Stores

Is now accepting your

Delaware Healthy Children Payment

**** Take your payment & invoice to the pharmacy counter in any Happy Harry's in Delaware**

**** We ask that you only make payment Monday-Saturday from 9am-6 pm.**

**** You can pay by credit/debit card, cash, check or money order (made payable to Happy Harry's)**

**** If you have any questions please contact The Health Benefits Manager at 1-800-996-9969**

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.

N*ote: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).*

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			

Insurance payments			
Managed care			
per member/per month rate X # of eligibles	2,391,215	Not Available	Not Available
Fee for Service	1,057,012	Not Available	Not Available
Total Benefit Costs	3,448,227	Not Available	Not Available
(Offsetting beneficiary cost sharing payments)	(269,163)	Not Available	Not Available
Net Benefit Costs	3,179,064	Not Available	Not Available
Administration Costs			
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs	343,846	Not Available	Not Available
10% Administrative Cost Ceiling	353,229	Not Available	Not Available
Federal Share (multiplied by enhanced FMAP rate)	2,289,891	2,307,500	2,388,750
State Share	1,233,019	1,242,500	1,286,250
TOTAL PROGRAM COSTS	3,522,910	3,550,000	3,675,000

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

Not Applicable

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

__xx__ State appropriations
_____ County/local funds
_____ Employer contributions
__xx__ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

- The current School Nurse Express grant expires June 30, 2002
- The current RWJ grant "Covering Kids" that has funded outreach activities and materials expires February 28, 2002.

The Medical Society of Delaware expects to apply for a new Robert Wood Johnson grant titled "Covering Kids and Families". If awarded, they plan to use funds to assist the Division of Social Services with outreach, retention, and coordination of health benefits.

Section 5: SCHIP Program At-A-Glance

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name		Delaware Healthy Children Program
Provides presumptive eligibility for children	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No _____Yes, for whom and how long?	__X___No _____Yes, for whom and how long?
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*	__X___State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*
Average length of stay on program	Specify months	Specify months : Six months
Has joint application for Medicaid and SCHIP	_____No _____Yes	_____No __X__Yes
Has a mail-in application	_____No _____Yes	_____No __X__Yes
Can apply for	_____No	_____No

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
program over phone	_____Yes	__x__Yes
Can apply for program over internet	_____No _____Yes	__X No ___Yes
Requires face-to-face interview during initial application	_____No _____Yes	___X__No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_____No _____Yes, specify number of months What exemptions do you provide?	_____No ___X__Yes, specify number of months __: 6 MONTHS What exemptions do you provide? Death or disability of parent, termination of employment, change to a new employer who does not cover dependents, change of address and provider network is not available in the county of residence, expiration of coverage under COBRA, employer terminates coverage for all employees.
Provides period of continuous coverage <u>regardless of income changes</u>	_____No _____ Yes, specify number of months: Explain circumstances when a child would lose eligibility during the time period	_____No ___X__Yes, specify number of months _12 MONTHS Explain circumstances when a child would lose eligibility during the time period*: Turns age 19, death, acquires comprehensive health insurance, eligible for State health benefits plan, incarceration, not a state resident, no longer qualified alien.*
Imposes	_____No	_____No

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
premiums or enrollment fees	_____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)	__X__Yes, how much? $10 per family per month(PFPM) with income bewteen 101%-133% FPL, $15 PFPM with income between 134%-166% FPL, $25 PFPM with income between 167%-200% FPL Who Can Pay? __X__ Employer __X__ Family __X__ Absent parent __X__Private donations/sponsorship _X__ Other (specify) :Anyone
Imposes copayments or coinsurance	_____No _____Yes	_____No __X___Yes $10 Emergency room (general policy)
Provides preprinted redetermination process	_____ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	___X_No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct __ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

The redetermination process and the initial application process are currently the same.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

200% of FPL for children under age _1_____
133% of FPL for children aged __1-5_____
100% of FPL for children aged _6 through 18

Medicaid SCHIP Expansion

____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged _____

Separate SCHIP Program

101-200% of FPL for children aged _1-19_____
____% of FPL for children aged _____
____% of FPL for children aged_____

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

____ Yes __X__ No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	$ 90	$	$ 90
Self-employment	$ cost of doing business	$	$ same
Alimony payments Received	$ N/A	$	$ N/A
Paid	$ N/A	$	$ N/A
Child support payments Received	$ 50 per child	$	$ same
Paid	$ N/A	$	$ N/A
Child care expenses	$ 200 under age 2 $ 175 age 2 and above	$	$ same
Medical care expenses	$ N/A	$	$ N/A
Gifts	$ N/A	$	$ N/A
Other types of disregards/deductions (specify)	$ ½ of gross parental income for pregnant teen	$	$ same

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

__X__ No ___ Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program

_____ Yes, specify countable or allowable level of asset test_____

State-Designed SCHIP program

__X__ No ____ Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____

____ No ____ Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001?

___ Yes __X__ No

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

A. Family coverage –No Change

B. Employer sponsored insurance buy-in –No Change

C. 1115 waiver –No Change

D. Eligibility including presumptive and continuous eligibility –No Change

E. Outreach –No Change

F. Enrollment/redetermination

The Division of Social Services expects to apply in February, 2002 for a Robert Wood Johnson grant titled "Supporting Families after Welfare Reform". The Division of Social Services expects to use the funds to develop and implement an automated passive redetermination process. A pre-printed form and cover letter with clear instructions would be mailed to familes for the yearly redetermination. Using a simpler form should reduce churning of children in DHCP when parents fail to complete redetermination promptly.

G. Contracting –No Change

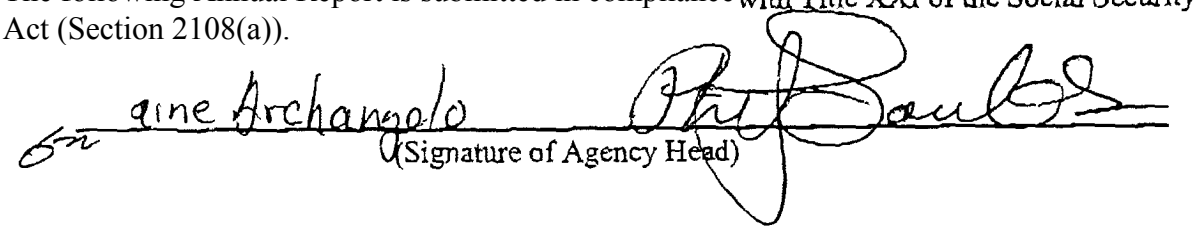
H. Other –No Change

Not Applicable

Federal Fiscal Year 2001
FRAME WORK FOR ANNUAL REPORT OF
STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: DELAWARE

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).



SCHIP Program Name(s): DELAWARE HEALTHY CHILDREN'S PROGRAM (DHCP)

SCHIP Program Type:
_____ Medicaid SCHIP Expansion Only
X_ Separate SCHIP Program Only
___Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/l/2000-9/30/2001)

Contact Person/Title: Philip P. Soulé, Sr., Medicaid Director

Address: Medical Assistance Program, Division of Social Services,.P.O. Box 906, New Castle, DE 19720

Phone: (302) *577-4900* Fax: *(302) 577-4899*

Email: psoule@state.de.us

Submission Date:

(Due to your CMS Regional contact and Central Office Project Officer by January .1, 2002) Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

Executive Summary

Delmarva/Mercer Team

The Delmarva Foundation for Medical Care Inc. (Delmarva) and William M. Mercer, Inc. (Mercer) Team (Delmarva/Mercer) serves as the External Quality Review Organization (EQRO) for the State of Delaware. The EQRO is charged with independently assessing the quality of health care services delivered to Medicaid recipients enrolled in the Department of Health and Social Services Health Plans (DHSSHPS). In this role Delmarva/Mercer has performed studies focused on cardiovascular preventive services for women, EPSDT services for children, guideline development for lead screening, and a re-measurement of a previously initiated immunization project.

The results of this comprehensive approach is presented with recommendations for improving the quality of care across these important preventive services.

Focus Clinical Studies

Cardiovascular Disease in Women

The study was undertaken to provide an assessment of quality of care factors related to cardiovascular **disease** screening in women **enrolled in** the DHSSHPs. The results of this study indicate significant **potential** for improvement across all 13 performance measures related to cardiovascular disease screening.

The indicators were divided into two separate categories including (1) lifestyle modification and (2) cardiovascular risk factors. The opportunity for improvement was apparent across both lifestyle indicators and the risk factor management indicators. In an apparent paradox of performance measurement it was noted that there was a high percentage (>80%) of documented medication compliance among those identified with hypertension, yet a low rate of actual blood pressure control (<30%). Clearly, more rigorous interventions aimed at the control of blood pressure are certainly warranted. Therefore, it is recommended that women's cardiovascular health be an area of focused quality improvement and that the comprehensive performance evaluation presented in this report serve as the baseline measurement against which improvement efforts can be assessed.

EPSDT Focused Clinical Study

Delmarva/Mercer performed a comprehensive assessment of the completeness and value of EPSDT services received by the cohort of children birth through 20 years of age. Medical records as well as administrative/encounter data were used to construct the comprehensive set of quality indicators which were based on the periodicity table of required services. The performance measures were analyzed by subgroups including age, sex, race, county of residence and eligibility status of the enrollee.

The results support the need for improvement across the entire set of EPSDT performance measures and across all subgroups. While data

collected from medical records suggest that 72% of eligible children had received at least one immunization service, only 19.8% had received all of the age-required immunizations as of the end of calendar year 1999 (CY1999). STD/HIV testing for adolescent enrollees age 14 and over was less than 2%, when measured using administrative/encounter data and less than 5% when measured using the medical records data. Documentation of the sickle cell screening and tuberculin test were also low. Yet the rate of primary care encounter for this group of children was high, as high as 98% for some age strata. It is strongly recommended that a quality improvement effort aimed at enhancing the delivery of EPSDT services across all required services and for all subgroups of enrollees be initiated. Further, it is recommended that a focus of the improvement project be maximizing the potential delivery of EPSDT services during each and every primary care encounter. Office-based systems need to be built that insure that each child receives every EPSDT service that is age appropriate during each primary care encounter.

Our qualitative analysis, enrollee focus groups and in-depth telephone interviews indicated that accessing care is a challenge and may contribute to the low level of EPSDT service completion rates observed. This is further evidence of the importance of maximizing the opportunity presented by each primary care encounter with each and every child.

In addition a rigorous validation of the encounter data as compared to medical record abstraction was completed. As is often the case with encounter data systems, the data was found to be reasonably accurate, that is services in the encounter database were verified as having been delivered by the medical record. The encounter data is not, however, complete as many more services were found in the medical record than were present in the encounter data. Therefore, although improvement efforts should be driven by analysis of encounter data, it is important to verify and complete performance measurement with a sample of medical records for detailed review and abstraction.

Clinical Practice Guidelines Project

The primary purpose of this initiative was to establish and implement a practice guideline in an area of clinical relevance to children enrolled in the DHSSHPs; monitor compliance with the guideline; and measure the improvement in overall health of the enrollees as a result of the guideline. Screening and management of childhood lead toxicity was considered to be a priority topic for the practice guideline project.

The following goals were established specific to the Lead Screening Guideline Project:

- Develop guidelines for the appropriate screening and management of lead toxicity
- Increase the lead screening rate in the pediatric population enrolled in the DHSSHPs
- Provide standardized documentation for the appropriate management of elevated blood lead levels (BLLs)

Based on Delmarva/Mercer's research, input from the Department of Health and Social Services (DHSS), the DHSSHPs, key stakeholders and the Lead Screening Guideline Committee, a uniquely designed, Delaware-specific Lead Screening Guideline was created. The Guideline Committee

composed of representatives from the DHSS, Division of Public Health, Medical Society of Delaware, American Academy of Pediatrics and practicing physicians were charged with ensuring that the guideline addressed local issues and represented the most recent scientific evidence. A brochure was then created to detail to practitioners the lead screening guideline. The brochure was mailed to Medicaid's primary care, pediatric and internal medicine providers, both managed care and fee-for-service providers throughout Delaware on October 20, 2000, to coincide with National Childhood Lead Poisoning Prevention Week, October 23-29, 2000.

Two sources of data were examined to provide an estimate of the existing levels of lead screening prevalent among the pediatric population of the DHSSHPs - the Delaware State Lead Registry and a comprehensive EPSDT study completed by Delmarva/Mercer in conjunction with its EQRO activities for the State. While both of these data sources are unrelated and differ significantly, both sources independently validate the finding that the rate of screening for lead poisoning among this population is inadequate.

While the development and distribution of the Clinical Lead Screening Guideline was an important first step in addressing the issue of lead toxicity among the children enrolled in the DHSSHPs, the following steps are recommended to fully realize the benefits of the guideline and effectively improve the health of this targeted population:

- Continuing to coordinate efforts with the participating DHSSHPs to provide evidence-based feedback and education to enrollees and providers **in an** effort to increase the **rate of** lead **screening in** the pediatric population
- Annual monitoring for the levels **of** lead screening and detection of new cases of lead toxicity, using available data sources to track and assess both the changing levels of physician compliance with the guideline and the impact of the guideline in improving health status
- Periodic meeting of the Lead Screening Guideline Committee to monitor new scientific evidence and/or regulatory changes and to make necessary changes to the guideline when required

At the end of a one-year study period, DelmarvalMercer recommends re-measurement of the rates for both childhood lead screening and newly diagnosed cases of lead poisoning. This re-measurement will provide the State with valuable information on the levels of provider compliance with the guideline recommendations and the overall impact of the guideline on the health of the pediatric population of the DHSSHPs.

Evaluation of Immunization Re-measurement Project

Delmarva/Mercer was charged with providing technical assistance in the development, and/or implementation of the immunization project and monitored the results of the quality improvement efforts undertaken by the DHSSHPs during CY1999. The original Immunization Study was conducted by the EQRO in 1997.

In response to the initial study findings, the DHSSHPs implemented quality improvement projects to improve the rate of the immunizations delivered to children enrolled in their plans. The

DHSSHPs utilized the HEDIS® Childhood Immunization Status measures to assess the Immunization Status for Combination 1, and Combination 2.

Table 1. Reflects the DHSSHP rates for the HEDIS Childhood Immunization Status Measures for CY 1999

HEDIS Measure	MCO I	MCO 2	NCQA's 1999 Benchmarks
Combination I	73.7%	68.9%	**64.8%**
Combination 2	**59.4%**	56.7%	51.9%

It is important to note that the DHSSHPs rates for both measures compare favorably to NCQA's 1999 national benchmark rates. In addition, MCO 2 had demonstrated increases in all areas of measurement from CY 1998 to CY 1999, and MCO 1 will undertake quality improvement interventions during CY 2001, and ongoing remeasurement will follow.

The fact that the DHSSHPs conducted a Childhood Immunization Project consistent with the HEDIS® specifications provides them with the ability to track immunization rates over time. MCO2 has used its data appropriately to track and monitor the overall immunization rate as well as the specific type of immunization/antigen rates. This has allowed MCO 2 to develop interventions targeting specific types of immunizations/antigens.

Conclusions and Recommendations

The report presents a comprehensive assessment of the quality of care in two important clinical areas – cardiovascular care for women and EPSDT services with special emphasis on immunizations and blood lead screening for children. It is clear from the comprehensive assessment of these two clinical areas that there is vast potential for improvement. These are important and necessary services to assuring quality of life for enrollees in this group. The report demonstrates the ability to measure a comprehensive set of performance indicators across these two important clinical areas and for two different and distinct enrollee populations, the two largest in the Medicaid program. A comprehensive measurement system has been built, as evidenced by the analysis presented in this report.

The next phase is using this measurement system for improvement purposes. Specifically the quarterly analysis approach is designed to assess the impact of interventions for improvement in time. It is imperative that the projects move into a cycle of intervention, improvement and continuous measurement to maximize the quality of healthcare delivery in these clinical areas. For women and cardiovascular health it is important to address outcome measures such as blood pressure control in addition to process of care measures. For EPSDT improvement efforts, a focus must be made on realizing the potential of each primary care encounter with each child